MINUTES
MEETING OF
INDIGENT & CHARITY CARE AD HOC COMMITTEE
Department of Community Health, Division of Health Planning
2 Peachtree Street, 34th Floor Conference Room
Atlanta, GA 30303

Friday, November 19, 2004
1:30 pm – 3:30 pm

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David M. Williams, MD., Chair, Presiding

MEMBERS PRESENT

Cal Calhoun
Jeffrey Crudele
Jim Connolly
Daniel DeLoach, MD
W. Douglas Skelton, MD
Tony Strange
Kurt Stuenkel, FACHE

MEMBERS ABSENT

Charlotte McMullan
Eric Randolph, MD

GUESTS PRESENT

Jennifer Bach, Gill/Balsano Consulting
Amanda Chambers, Rockdale Medical Center
Brian Crevasse, Parker, Hudson, Rainer & Dobbs
Joy Davis, Rockdale Medical Center
Lori Jenkins, Phoebe Putney
Stan Jones, Nelson Mullins
Bill Lewis, Phoebe Putney
Scott Rees, Powell Goldstein
Kevin Rowley, St. Francis Hospital
Temple Sellers, Georgia Hospital Association
Helen Sloat, Nelson Mullins
Deborah Winegard, Medical Association of Georgia

STAFF PRESENT

Neal Childers, JD
Richard Greene, JD
Matt Jarrard
Robert Rozier, JD
Rhathelia Stroud, JD
Geeta Singh
Stephanie Taylor

WELCOME AND INTRODUCTIONS

David Williams, MD, Chair, welcomed members and guests to the second meeting of the Indigent & Charity Care Ad Hoc Committee. The meeting commenced at 1:45 pm

REVIEW AND APPROVAL OF MINUTES OF OCTOBER 21, 2004 MEETING

Dr. Williams asked for a motion to approve the minutes of the October 21st meeting. Kurt Stuenkel said that his comments to the committee, regarding the use of "charges" in the calculation of charity care, were inaccurately captured in the minutes of the October 21st meeting. He said that his comments should have been recorded as follows: "as long as a facility's gross charges are used in both the numerator and the denominator of the calculation for each facility, a ratio would result and this would provide a basis of comparison from facility to facility". Department staff agreed to make the corrections to the minutes. The committee voted unanimously to accept the minutes, following the insertion of this language.

DELINEATION OF ISSUES IDENTIFIED BY THE DEPARTMENT

Dr. Williams called on Robert Rozier to discuss issues that were identified by the Department with regard to Indigent and Charity Care. Mr. Rozier acknowledged that these issues are very intertwined and outlined them as follows:

- BILL COLLECTION FOR ICC PATIENTS
  The Department requested guidance on when the designation of indigent and charity care should be made. Mr. Rozier said that language included in the Department's draft proposed Health Planning Rules indicates that patient care should not be designated as "indigent" or "charity" once a collection effort has been initiated.
- ICC DESIGNATIONS AS A PERCENTAGE OF FEDERAL POVERTY LEVELS
  Department requested guidance concerning how to determine the percent designation (of federal poverty levels) to use for charity care in the proposed rule. The designation for Indigent care is clearly set at a maximum of 125% of the FPL. Also, the Department asked the committee to determine whether it is appropriate to distinguish charity care from bad debt by placing an upper limit on charity care.
- DETERMINING FLEXIBILITY IN PROVIDER CHARITY CARE POLICIES
  The Department asked for guidance on how to provide flexibility to providers regarding their individual charity care policies and what deference should be given to those policies.
- DISTINGUISHING BAD DEBT AND CHARITY CARE
  The Department asked for guidance on how to appropriately distinguish charity care from bad debt.
- USE OF CHARGES VERSUS REIMBURSEMENT

The Department requested guidance with regard to the use of "charges" versus "reimbursement rates" in the calculation of charity care. Mr. Rozier indicated that most

facilities with multiple CONs, under certain service-specific rules and on an institution-wide basis, meet the 3% charity care commitment, however, the Department would like some guidance on an appropriate calculation measure that would ensure that all healthcare facilities are offering the same minimum level of indigent and charity care and that there is some mechanism to make comparable statewide comparisons for all providers with such a commitment. He clarified that the Department is trying to determine a standard method for reporting the data so that it can be used in determining the financial accessibility of statewide facilities, for CON purposes. He said that in the proposed Health Planning Rules, the Department made the recommendation that calculation of charity care be based on "average reimbursement" rather than "charges".

PUBLIC COMMENTS

Dr. Williams called on guests to provide public comments. Noone indicated the desire to provide public or written comments to the committee.

REVIEW OF PROPOSED INDIGENT & CHARITY CARE RULE & COMMITTEE DISCUSSION

Dr. Williams called on Rob Rozier to review the proposed Indigent and Charity Care Rule. Mr. Rozier indicated that the Department's draft definitions relating to indigent and charity care are contained in member packets. He stated that the basic difference between the first and second draft of the definition of bad debt, is the inclusion of language that reads as follows: "Forgone revenue shall only be considered bad debt if such forgone revenue is recorded to a bad debt account and a detailed list of such account is maintained." Mr. Rozier also highlighted the major changes in the definition for charity care. He noted that the draft charity care definition includes language about "internal" and "external" collection efforts.

In response to Mr. Rozier's remarks regarding collections and billing, Daniel DeLoach said that many times, incomplete or inaccurate information is provided during admission through the emergency room. He said that the only time it can be accurately determined that a patient has no insurance or is eligible for indigent or charity care is often after an invoice for services has been sent.

Jeff Crudele asserted that the Committee might want to recommend that providers record accounts in the appropriate manner, so as not to cause undue administrative burden when trying to gather data. He suggested that hospitals should be allowed the flexibility to gather information in a reasonable fashion, using reasonable tools. Further, he stated that once the determination is made that providers should cease any collection activity efforts. Mr. Crudele said that providers can use collection and information gathering techniques in order to classify patients correctly.

Mr. Rozier clarified that the Department's issue with parity is in trying to come up with a

comparable way the to look at all CON applications. He said that, at present there is no mechanism to ensure that the 3% commitment is the same, for all providers, since each has different reimbursement rates and substantially different charges. Mr. Crudele suggested that using charges, as in the current methodology, in both the numerator and the denominator neutralizes any issues associated with trying to cross compare one provider to another in terms of whether they are trying to do more or less charity care.

Mr. Greene stated that the current calculation uses gross charges, which are totally unregulated and wide open to interpretation. He asserted that he does not agree that the current formula provides a good basis for comparison. He said that the situation was a lot different four years ago because other things were included in the adjustments that are not included today.

Mr. Crudele clarified his comments noting that the current formula provides for charges in the numerator and denominator. He agreed with Mr. Greene that there are elements in the denominator that are adjusted, but pointed out that the impact of a provider moving its charges up is taken into consideration in both the numerator and the denominator of the calculation, as it exists today.

Rob Rozier proceeded with his explanation of the Department's proposed definition of charity care and pointed out that there is currently no financial cap in the determination of charity care, since this measure is separately defined by the policies of each institution. He noted that indigent care is capped at 125%of FPL currently. He pointed out that the original draft of the definition stated that the charity care designation had to be made before an invoice was sent. This requirement was changed in the second draft to indicate that the patient account could never be subjected to "internal" or "external" collection processes.

Following this discussion, Kurt Stuenkel made a motion, seconded by Dr. DeLoach, that the committee retain the current methodology, including the use of "charges" and not use "average reimbursement" as is indicated in the Department's proposed methodology. He said that the committee should refine and create clearer definitions associated with the current methodology so that those definitions could be applied consistently. He stated that staying with the current methodology provides a summary number that is comparable from ambulatory facility to hospital and other providers.

Rob Rozier pointed out that the current methodology that the Department uses is not written in any rule. He said that the Department wanted to insert this calculation in a rule so that there would be clarity surrounding how the calculation is made.

Dr. Williams restated the motion made by Kurt Stuenkel and asked if anyone wanted to discuss the motion further.

Jim Connolly objected to the motion by explaining that the "charges" in the denominator, in

the Department's current methodology, do not appear to be consistent for all providers, considering variations that exist, given the mix of Medicare/Medicaid and managed care business.

Tony Strange asserted that providers that do not have much managed care business would have a higher indigent care rate than providers with a larger share of managed care business.

Dr. Williams requested that the committee table the motion that was made by Mr. Stuenkel since he felt there was still some additional discussion that was needed to resolve a few outstanding issues. Both Mr. Stuenkel & Dr. DeLoach agreed.

Dr. Williams urged the committee to put forth definitions for indigent and charity care that are clear, concise, and capable of consistent application. Further, he thanked those who submitted written comments and asked if committee members found a desirable definition for charity care in the definitions that were submitted by the Hospital Corporation of America (HCA) or Georgia Hospital Association (GHA).

Cal Calhoun stated that three months ago GHA's Board invited some of its members to join a workgroup to discuss charity/indigent care policies. He stated that the group met after this committee's first meeting and developed some recommended definitions. These definitions were submitted to the Division of Health Planning and forwarded to the Indigent & Charity Care Ad Hoc Committee. He pointed out that Jeff Crudele was one of the members on that workgroup, which resulted in similar definitions submitted by Georgia Hospital Association and Hospital Corporation of America.

Dr. Skelton called everyone's attention to the definitions that were drafted by the Department and asked if there were any objections to the last sentence of each of the draft definitions that the Department has proposed for indigent care, charity care and bad debt, namely, "Forgone revenue shall only be considered indigent care if such forgone revenue is recorded to an indigent care account and a detailed list of such account is maintained"

Mr. Calhoun indicated that he did not have a problem with the last sentence of the definition, but questioned other areas of the definition.

Dr. DeLoach stated that there is confusion over definitions that were discussed at today's meeting. He questioned the definitions of "internal" and "external" collections and requested clarity on the meaning of the words "collections" and "billing".

Mr. Rozier pointed out that there is also a timing issue as to when the collection efforts should be made. He noted that the Department's proposed definitions mention an "external" collection effort and not "internal" because of the obvious difficulty in defining an internal collection effort.

Mr. Calhoun pointed out that the Principles & Practices Board Statement of the National Healthcare Financial Management Association on timing and determination of eligibility of charity services states, "collection efforts can yield essential information about the amount of charity service for which a patient is eligible. Commencement of collection efforts does not alter the patient's financial status. Providers' collection efforts include use of outside collection agencies as a part of the information collection process and can appropriately result in identification eligibility for charity service."

Mr. Stuenkel responded that he believed "collections" to be when a provider retains a firm to facilitate collection of monies, while billing is the normal administrative process.

Mr. Strange stated that any of the efforts that his facility undertook internally would not be considered part of a collection effort but would be considered part of the billing process. He said that he perceives "collections" to be a third party who goes after the patient and starts attacking patients' assets.

Dr. Williams suggested that the group define the term "collection efforts", so as to clear up the question over "collection" versus "billing".

Mr. Crudele stated that if the information obtained from a patient is incomplete or inaccurate, the inquiries that a facility makes may not be a collection effort, but may be an effort to obtain additional information in order to send an invoice to the patient.

Dr. Williams recommended that Mr. Rozier and the Department further clarify the definitions of "collection" and "billing" in the draft health planning rules.

Mr. Rozier responded that the Department perceives "collections" to be a process where an account is forwarded to an outside agency in order to obtain credit checks and to affect someone's credit record. He said that the Division of Health Planning has conducted an analysis of definitions of indigent/charity care/bad debt from other states. Using this information, roughly half of the states placed restrictions on provider's ability to send patient accounts through a "collections" process. He offered to look more in depth at other state statutes prior to the next meeting, to get a better understanding of how "collection efforts" are defined.

Dr. Williams asked if the group could agree on how to define "external" collection efforts. He indicated that an external collection effort could be defined as sending a patient's account to a collection agency that could affect the patient's credit. He said that an initial attempt to collect money usually does not affect one's credit.

Rhathelia Stroud suggested that the committee also should consider including the referral of an account to a third party, whose purpose in doing so, is for the sole purpose of retaining a percentage of any outstanding balance, as another facet of a "collection" process.

Mr. Strange stated that Ms. Stroud's definition would not be overly burdensome for home health providers since "collection" efforts are defined, in his industry, as outsourcing to a recovery agent who is expected to retain a percentage of the recovery amount.

Ms. Stroud pointed out the difference between an external billing party and a recovery agent. She stated that the external billing agencies are paid a fee by the hospital for billing services, recovery agents, on the other hand, retain a percentage of what is received from the patient.

Mr. Crudele agreed that the committee was on the right track when trying to determine the definition of collection efforts. He suggested that some language such as "aggressive collection efforts", which exemplifies third party collection agencies, or some language that captures the intent of a third party agency be inserted in the definition. He stated that in order to get a definition that is more substantive, the question of how the patient is being affected has be considered. He said that liens are a very good example because when a provider places a lien on a patient's property, this is a clear collection effort.

Dr. Williams asked if the Department would consider defining a "collection" effort as an effort in which the outcome may cause an adverse affect to the patient's financial status (credit scoring/lien/judgment). Also, he asked the committee to consider whether the intensity of the effort, (i.e., number of phone calls) could be used in the definition.

Dr. DeLoach disagreed with placing a limit on the number of attempts made by the hospital at sending bills or contacting patients, because he said, many times patients do not respond. He stated that providers are unaware that patients do not have any money until their accounts are turned over to collection agencies.

Dr. Williams agreed and asked the Department to clarify their main concern as it relates to the collection process.

Ms. Stroud stated that one of the Department's major concerns is to try to get hospitals to identify patient financial status (indigent/charity) at the earliest possible stage during the patient encounter.

Mr. Crudele stated that a core issue in the identification of patient status early in the encounter is communicating with the patient so that they could be advised of potential avenues that they could utilize to satisfy the bill.

Mr. Rozier asked committee members if they would agree to add to the proposed definition some language that indicates that all patients should receive some financial counseling prior to any indigent/charity care designation. Mr. Crudele said that he did not believe that all patients need financial counseling, however when a patient is unable to present suitable forms of payment, then there is an obligation to have some dialogue with the patient to try to

assist in that process. He stated that to uniformly provide financial counseling to every patient is unnecessary and a poor utilization of resources. Mr. Calhoun stated that the hospital policy manual has requirements linked to patient financial reporting, for hospitals participating in the Indigent Care Trust Fund. The policy indicates that an applicant's statement of zero income may be accepted.

Dr. Williams commented that sliding scales have worked very well at his facility, Southside Medical Center, a local community health center.

Because the end of the committee's meeting time was quickly approaching, Dr. Williams recommended that the Department follow-up on several of the issues that were discussed at today's meeting so that some areas can be resolved at the next meeting.

SCHEDULE OF UPCOMING MEETINGS

There was a request from a committee member to change the date of the upcoming December 3rd meeting to Friday, December 10th. Dr. DeLoach suggested an extension of the meeting time, noting that it would be beneficial for those traveling long distances and would allow more time to resolve several issues. Following committee discussion, it was agreed that the next meeting would be held on Friday**, December 10, 2004 from 11:00 am - 3:00 pm at Southside Medical Center, 1046 Ridge Avenue, SW, Atlanta, GA 30315.** Travel instructions would be mailed to members.

ADJOURNMENT

Dr. Williams urged the group to continue to send any written comments to Stephanie Taylor at sttaylor@dch.state.ga.us or directly to him at david.williams@southsidemedical.net

There being no further business, the meeting adjourned at 3:15 pm. Minutes taken on behalf of Chair by Geeta Singh and Stephanie Taylor.

Respectfully Submitted,

David M. Williams, MD, Chair